

Editorials and Association Notes

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New Feature

It is proposed to run a column on Therapeutics for the next few months as a new feature of the Manitoba Medical Review. To begin with, emended extracts from the recently issued *Internes' Handbook* of the Winnipeg General Hospital will be offered. The first extracts appear in this issue.

Comments from readers are invited, and suggestions for future topics in this column would be appreciated.

Obituaries

Dr. Sara Meltzer

Dr. Sara Meltzer, Associate Pathologist of Winnipeg General Hospital, died October 11 in the hospital where she had worked for eighteen years. Born in Winnipeg in 1900 she studied in St. John's Technical School and Manitoba Medical College from which she graduated in 1924. She then joined the pathological department of the Winnipeg General Hospital where she continued without interruption save for post-graduate work under Dr. Masson, University of Montreal, and Dr. James Ewing, Cornell Medical School, New York. Under Professor William Boyd and Professor Daniel Nicholson her reputation as a tissue pathologist and teacher steadily rose. In 1937 she was appointed lecturer in Pathology in the Faculty of Medicine, University of Manitoba, and Associate Pathologist, Winnipeg General Hospital. She also lectured for many years to the student nurses of the hospital. She is survived by her father, three sisters and four brothers, three of whom are in the Canadian Forces, and one of them, Capt. Herbert Meltzer, R.C.A.M.C., formerly surgeon at Manitoba Sanatorium, Ninette, is now serving overseas.

By herself and with other members of the staff Dr. Meltzer published papers on rheumatic fever, thyroid disease, relation of neurological lesions to gastric ulcer and findings in experimental tar cancer.

Dr. Sara was beloved for her qualities of mind and heart. Her untimely death is a real loss to the hospital and the college.

Dr. C. William Green

Dr. Charles William Green died at Winnipeg on September 23. Born in the Isle of Wight, he was educated at Southampton; then, coming to Canada, he entered Manitoba Medical College, graduating in 1910. After post-graduate work in London, he returned to Canada in 1912, but on the outbreak of war he enlisted in the R.C.A.M.C. On his return from overseas he resided in Winnipeg. He was a member of the Winnipeg Cricket Club and of the Public School Boys' Association.

Capt. Francis W. Hayter at Dieppe

Capt. Hayter was ashore with the South Saskatchewan Regiment for the entire period of the action at Dieppe and demonstrated the highest order of personal courage and devotion to duty under very trying conditions. He established three R.A.P.s (regimental aid posts) and constantly moved through heavy mortar and machine-gun fire from one to another.

On the beach while evacuating the wounded he was subjected to intense artillery fire and dive-bombing but persisted in his task, and personally saw that all who could be taken were embarked before he himself would go aboard.

Throughout the entire return journey and afterwards at a shore hospital, Capt. Hayter carried on for more than 24 hours to ensure the comfort and safety of the men under his care.

(Capt. Hayter, in civilian life a medical doctor, was born June 28, 1907. He was educated at public schools in Alameda, Sask., and Winnipeg; Daniel McIntyre Collegiate, Winnipeg; the University of Manitoba and the Manitoba Medical College, from which he graduated in 1933.

(Capt. Hayter's military career began when he was commissioned in the Royal Canadian Army Medical School at Regina, May 10, 1940. After going overseas, Captain Hayter was attached to the 9th Field Ambulance and later to the 2nd Anti-Tank Regiment and finally to the South Saskatchewan Regiment.)

American College of Surgeons Cancels Clinical Congress

The annual Clinical Congress of the American College of Surgeons which was scheduled to be held in Cleveland November 17-20, 1942, was cancelled by the Board of Regents of the College at a meeting held on October 14. The Regents were influenced by the present conditions surrounding the general war programme which have led to a greater burden on the members of the surgical profession in their local communities.

Therapeutic Section

Care of a Comatose Patient

The chief causes of death in the comatose are pulmonary oedema and pulmonary infection.

Urine: If bladder enlarges so that it can be felt or percussed put in retention catheter and empty bladder four-hourly. Sulfathiazol administration will tend to prevent urinary infection. Try to maintain urinary output at 1000 cc's. daily or more.

Fluids: Nourishing fluids and medication may be given t.i.d. after shoving a large Ewald stomach tube down the throat for at least 18 inches beyond the lips (to make sure it is not in the trachea). This procedure (called "gavage") is usually simple and speedy and about one-third as much trouble as an intravenous. Clamp Ewald tube before withdrawal to avoid spilling contents down larynx.

If intravenous fluids are given remember that each liter of normal saline contains 9 grams of salt, which is an adequate sodium intake for 24 hours if the patient is not dehydrated or vomiting. Too much sodium will give oedema of the body or lungs. Extra fluid may safely be given as 5% glucose in distilled water.

Air: Any deeply unconscious patient needs an airway, or preferably an Endotracheal tube. This tube not only protects against suffocation but it prevents inhalation of vomitus. A catheter may be inserted into the tube when necessary for aspiration of mucus.

100% O₂ for 12 hours on and 4 hours off, via B.L.B. mask, helps to prevent generalized, and in particular cerebral, anoxia.

Occasional CO₂ inhalation helps prevent atelectasis and improves muscular tone.

Medication: If gavage is used, 2 powdered sulfathiazol tablets may be given with the fluids via Ewald tube t.i.d. If the intravenous method is preferred 1 gram sodium sulfathiazol may be given intravenously t.i.d. The purpose of this drug is to prevent pneumonia and urinary infection.

Shock: Watch for haemoglobin concentration, pulse rise, and blood pressure fall, as signs of shock, and treat accordingly.

H. W. B. Burns: Remember that an unconscious patient is easily burned and that hospitals are often sued on this account.

Shock (Capillary Atony and Anoxia)

Diagnosis: A rising haemoglobin% (if there is no haemorrhage) is one of the earliest signs. Pallor, perspiration; rapid, thready pulse; semi-consciousness or unconsciousness; low blood pressure. Hourly observation of pulse and blood pressure.

Treatment

- Elevate extremities or place patient in Trendelenburg position.
- Keep patient warm. Hot water bottles and blankets.
- In giving fluids, be careful not to increase haemorrhage. If blood is not available immediately, use serum, plasma, 6% gum acacia, or 500 to 1000 cc. of 10% dextrose solution in physiological saline, intravenously, at the rate of 15 cc. per minute.
- Give respiratory stimulants—caffeine with sodium benzoate, gr. 7½ subcutaneously.
- If no danger of increasing haemorrhage, give gr. ¾ by mouth or intravenously.
- 100% oxygen by B. L. B. mask.
- Cortin 20 cc. intramuscularly, if patient's condition is critical.

Medical Causes of Shock: Acute yellow atrophy, Addison's crisis, diabetic coma, anaphylaxis, Hg Cl₂ poisoning, food poisoning, diphtheria.

Haemorrhage

If the cause of haemorrhage is not obvious and a transfusion is about to be given, it is most important to do a full blood count before the blood picture is changed by the transfusion.

Gastric Haemorrhage

- Absolute bed rest.
- No food or drink by mouth till nausea ends. The Meulengracht diet plus Ferrous Sulphate gr. 5 t.i.d. The mortality rate under the old starvation treatment was very much higher than it is under Meulengracht's method of early feeding.
- Proctoclysis if indicated.
- Blood grouping in case transfusion necessary. Transfusion if blood pressure falls under 90 or haemoglobin under 40.
- Morphine if patient is restless. If morphine is not tolerated (causes vomiting) give soluble barbitol, gr. 3 to 5, intramuscularly. Morphine should be avoided if cirrhosis is suspected.

Pulmonary Haemorrhage

- Absolute bed rest in semi-sitting position.
- Sodium amytal 3 grains.
- Codeine gr. ½ by hypo if cough is distressing.

Nasal Haemorrhage

Most nasal haemorrhages are from Hesselbach's area. Haemorrhage may be controlled by inserting a large pledget of absorbent cotton saturated in cocaine 10% with Adrenalin inserted into the nostril and pressure applied from outside with finger-tip by the patient.

Next day the bleeding point may be localized, cocaineized and cauterized with silver nitrate fused on an applicator.

Catheterization of Males

Any patient unable to void is given one tablet of Prostigmin by mouth at once. If still unable to void the dose is repeated in one hour. Catheterization is only resorted to at the end of the second hour or when discomfort becomes severe. In post-operative patients Prostigmin is found to obviate about 80% of catheterizations.

1. Wash the penis with green soap and water, then wrap the glans in a sponge soaked in weak bichloride solution for 3 minutes.
2. Squirt a little sterile K Y jelly on the meatus.
3. 16 F catheter is held by sterile forceps near the point. The other end is held between the 4th and 5th fingers of the forceps hand. Do not allow the part of the catheter which is to enter the penis to be touched by any object except the meatus and the forceps. The left hand holds the penis. The catheter is pushed in by the forceps, taking new grips with the forceps as the procedure continues.
4. If this method fails, don gloves and manipulate the catheter. If unsuccessful squirt 5 cc. sterile K Y jelly into urethra with a syringe and try again. If still unsuccessful give an opium suppository and put patient in a sitz bath for 30 minutes. Then try again with an ordinary catheter and a filiform catheter. Never use a metal one. If failure, call a specialist or do a suprapubic aspiration.
5. All patients over 50 and any others in whom urinary infection is feared (e.g., paralytics) are to have one tablet of Sulfathiazol b.i.d. for 3 days after catheterization, starting immediately after the procedure.

Oxygen Therapy

Indications for oxygen therapy. This type of therapy may be indicated in:

Pneumonia	Carbon monoxide poisoning
Acute massive atelectasis	Postoperatively
Pulmonary embolism	Pulmonary oedema
Severe hay fever	Post-operative distension
Status asthmaticus	Subcutaneous emphysema
Acute coronary occlusion	Air embolism
Cardiac disease with decompensation	Encephalography headache
	Gas gangrene

Cyanosis, dyspnoea, and a rapid pulse are the most accurate indirect guides as to the advisability of oxygen therapy. Further, a fall in pulse rate is the best clinical evidence that instituted oxygen therapy is effective.

In the absence of cardiac decompensation, the degree of cyanosis in cases of pneumonia is usually proportionate to the degree of oxygen unsaturation of the arterial blood. Usually the cyanosis in pneumonia is lessened or abolished by oxygen administration. Also there is usually a parallel decrease in the amount of dyspnoea. In pneumonia it is wise to continue oxygen administration until there is no further clinical evidence to suggest oxygen want.

In massive atelectasis and pulmonary embolism the presence of dyspnoea and cyanosis are the chief indications for oxygen therapy. In both of these conditions the beneficial effects of oxygen administration may be very striking. In pulmonary embolism give 1/50 grain Atropine and Papaverine gr. 1/2 intravenously immediately.

In acute coronary occlusion there may be a general tissue anoxemia for several hours or days. Further, it is suspected by many that the occluding process per se may reduce the oxygen supply of certain portions of the myocardium to extremely dangerous levels. Here again it is wise to continue oxygen therapy until cyanosis and precordial pain have disappeared.

In carbon monoxide poisoning there is evidence that increasing the partial pressure of oxygen in the inspired air tends to hasten the breakdown of the relatively stable compound formed by carbon monoxide and haemoglobin.

CO₂ Therapy in Atelectasis

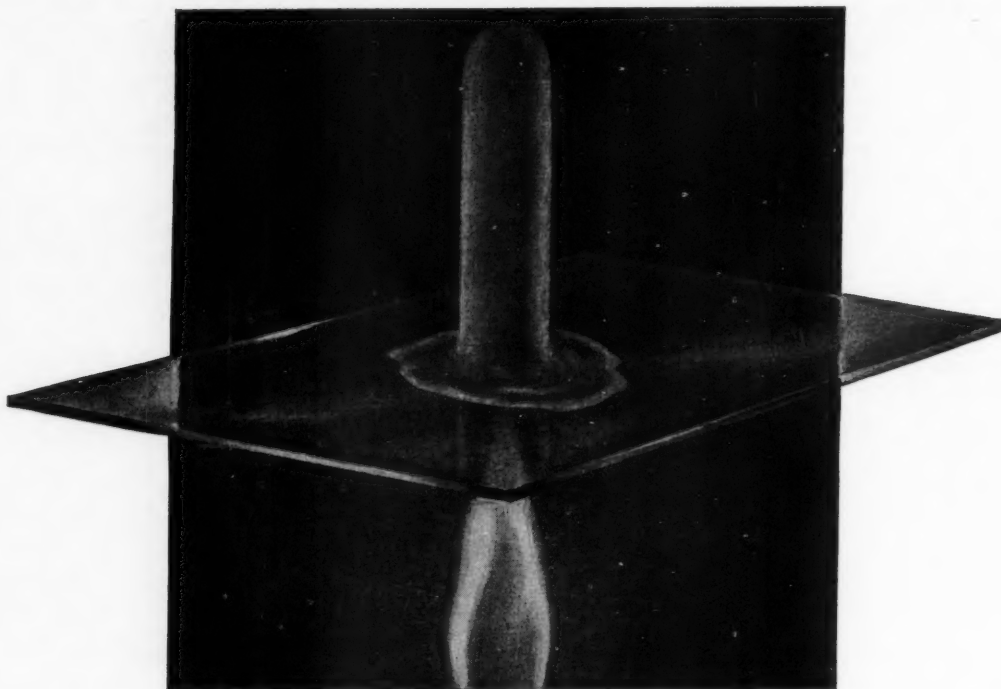
In patients with incipient or established atelectasis CO₂ inhalation should be tried to make the patient breathe deeply and cough. Pure CO₂ is released under the patient's nose through a hose (previously sterilized in biniodide) until the breathing is very deep. He is encouraged to cough. This may be repeated in 1/2 hour. If this fails in a patient with atelectasis, a catheter should be passed into the trachea by the direct laryngoscope, to induce cough. If the physical signs and symptoms are not relieved, an emergency bronchoscopic aspiration is indicated. Sulfathiazol will help to prevent pneumonia.

Administration of Oxygen Therapy

The nasal catheter is based on the principle that oxygen delivered through the nose into the oropharynx at the level of the uvula determines a definite alveolar oxygen tension the extent of which depends primarily upon the rate of flow. Approximately 8 liters per minute should be allowed. This gives the inspired air an oxygen concentration of about 60%.

The B.L.B. (Boothby) mask allows delivery of almost 100% oxygen to the lungs. Expired air is eliminated from the system through a valve arrangement. The flow of oxygen from the pressure tank is most effective when maintained at from 6 to 10 liters per minute.

Oxygen treatment of abdominal distention, subcutaneous emphysema, air embolism, encephalography headache. This type of treatment is based upon the observations that most of the distending air in the bowel is swallowed nitrogen and that reduction of the partial pressure of nitrogen in the blood stream causes a diffusion of nitrogen out of the intestinal lumen into the blood. By giving pure oxygen and eliminating the nitrogen as it is expired (B.L.B. mask) the nitrogen in the bowel is gradually removed.



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War Medicine

National Defence Headquarters, Ottawa, has recently announced the appointment of Brigadier G. B. Chisholm as Director General of Medical Services, Royal Canadian Army Medical Corps; also the appointment of Brigadier J. C. Meakins as Deputy Director General of Medical Services in charge of Professional Activities, Royal Canadian Army Medical Corps, and Colonel G. A. Winfield as Deputy Director General of Medical Services in charge of Administration. Brigadier R. M. Gorssline, who was formerly Director General of Medical Services, is appointed Inspector of Hospitals.

Brigadiers Chisholm and Meakins served with distinction in the last Great War, the former winning the M.C. and Bar, while Brigadier Meakins was mentioned in despatches twice for outstanding professional work. Colonel Winfield has been overseas two years, and was in charge of hospitalization in Canadian Military Headquarters, London, previous to his return to take up his new appointment.

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The purpose behind the division of duties of the Deputy Director General of Medical Services is to permit greater attention being given to the professional aspects of the Royal Canadian Army Medical Corps. It is proposed under the Deputy Director General of Medical Services (Professional) to appoint additional consulting physicians, surgeons and psychiatrists to assist the professional personnel in the various military districts. These consultants will have their headquarters in Ottawa, but will keep in close personal touch with the districts under their supervision.

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Special Reception Centres are now being set up where Boards will examine all applicants for enlistment. These Boards will consist of Medical Officers possessing outstanding professional qualifications for this type of work. Each Board will consist of a physician, a chest specialist, a surgeon, an orthopedic surgeon, a psychiatrist and an eye, ear, nose and throat specialist, together with a radiologist and Personnel Selection representative. The purpose of this move is to follow more rigidly the physical standards, so as to prevent men getting into the Services who either break down soon after enlistment and become "E" Category men, or those who upon examination show that they are "E" Category at the time of enlistment. The work of these Boards is most important and necessitates the most careful physical and mental examinations, in order that only those who are in acceptable categories for military duties are inducted into the Army.

Female physicians are now being accepted into the Royal Canadian Army Medical Corps, both as specialists and general practitioners. Female medical students may now be permitted to enlist in the Royal Canadian Army Medical Corps under the Government's accelerated plan of medical education. This plan provides enlistment for students for a period not to exceed twenty-four months, such period to include internship either before or after graduation, in accordance with the curriculum of the particular University concerned. The total period in all cases will include internship, and the twenty-four months is therefore divisible into three periods, which in some universities takes third, fourth and fifth year, while in others it takes fourth and fifth year and eight months' internship.

If male medical students are fit they are taken on as Privates, given the pay of Privates—\$1.30 a day plus \$1.00 subsistence—and granted leave of absence.

Female medical students are taken on as members of the Canadian Women's Army Corps. During such time as the medical school is not in session students shall be liable to do duty with their unit, or be detailed for such military or professional duty as may be directed by the District Medical Officer.

Book Review

War Medicine, a Symposium, edited by Winfield Scott Pugh (Philosophical Library, 15E. 40th St., New York City), August, 1942. \$7.50.

This well illustrated book of 565 pages contains 57 articles by well known English and American writers including Max Page, C. P. Wakeley, Foster Kennedy, Grey Turner, J. G. Scadding, G. Gordon-Taylor, R. C. Brock, Winnett Orr, Bishop Harman and Alvin Barach.

The articles, which were originally published in such journals as the British Medical Journal, The Military Surgeon, and The American Journal of Surgery, are here grouped in the main divisions of Surgery, Aviation and Naval Medicine, and General Medicine, and each division is sub-grouped as far as possible.

The method of compiling this book naturally leads to some overlapping and to some diversity of opinion, but taken as a whole it is an excellent symposium of war medicine and will be invaluable to medical officers in the services.

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MEETINGS

Third Friday, each month

Next Meeting

November 18th

MEETINGS

Start exactly at 8:15 p.m.

NOTICE BOARD

The October meeting was devoted to polio. First Dr. Bruce Chown spoke on the changed conception of the pathology. Then Dr. Deacon talked about treatment, the conception of which also has changed. A year ago, you may remember, we had a symposium into which treatment entered very little. That was B.S.K. (before Sister Kenny). Then her name evoked a smile or a laugh or a joke; at this meeting she dominated the scene. Her ideas of spasm, alienation and substitution, were explained and illustrated by Dr. Deacon and Mrs. Ross and glowing reports were given of the results her treatment has achieved.

In leading off the discussion, Dr. J. D. Adamson pointed to the palate which could neither be fomented nor splinted, yet always recovered from its paralysis. From this he inferred that if left to themselves patients would probably do quite as well as if they were treated. I expected some surgeon to jump up and say "In other words you would treat them medically." This would almost certainly have caused a great laugh as surgeons like to regard "medical treatment" and "doing nothing" as synonyms. However, either because they were too considerate or not bright enough, no surgeon made the sally.

The discussion was continued by Dr. Angus Murray, who showed a great knowledge of the Scriptures and expressed a great ignorance of Nurse Kenny's ideas. This might be expected for while God's Book is easily comprehensible to man, Nurse Kenny's book is incomprehensible even to God. Unlike St. Paul, Dr. Murray had not seen the "great light" which seems to have turned sceptics into converts elsewhere; or rather, out of a wide knowledge and great experience, looked upon it as an "ignis fatuus." Dr. Gardner also had not yielded to Nurse Kenny's persuasion and, while he did not altogether condemn, he did not greatly praise. Indeed, the orthopedists seemed to regard it as the rejuvenation of an old method rather than something new, and were inclined to let the verdict of time precede their own.

Duke in "As You Like It" found "tongues in trees, books in the running brooks, sermons in stones and good in everything," but he would have been surprised to learn the extent to which modern science has gone in finding "good in everything." To be sure we have not yet equal-

led the Egyptians who found great virtue in fly specks and a sovereign panacea in the excrement of scribes, but we are getting there! The latest refuse to give up a valuable therapeutic secret is spoiled sweet clover. There is in spoiled hay a substance that causes a haemorrhagic disease in the cattle that eat it. This substance, briefly called coumarin, prolongs the coagulation and prothrombin times and thus retards or prevents intra-vascular clotting. In this action it resembles heparin, but unlike heparin it is inexpensive and can be given by mouth. Dr. A. Hollenberg will tell us about it at the November meeting in his paper on "Dihydroxy coumarin and its use in Post-operative Thrombosis."

Having been instructed how to escape from the Charybdis of intra-vascular clotting we then proceed to learn how to deal with the equally dangerous Scylla of uterine bleeding. The ancient therapists had the choice, amongst others, of greater plantain, lesser periwinkle, orange peel and lentils. At that, the resulting brew would probably taste no worse than the late Mrs. Pinkham's well-known nostrum, and would possibly be quite as effective. And I can't imagine Galen or Aretaeus losing any sleep because he had prescribed the lesser periwinkle instead of the greater plantain or vice versa. The modern therapists with their more numerous and more potent remedies have greater difficulty in deciding what to use. In menopausal bleeding the quickest and most final way to settle the matter would seem to be the removal of the bleeding organ. But a good surgeon is one who knows when not to operate and when that is his decision then the radiologist has his innings. Dr. Wheeler has been making a study of the subject and will give his results in a paper entitled "Menopausal Bleeding and X-Ray Therapy."

These two papers will furnish a rich and meaty educational banquet. Now it is proper that the last course on such a menu should be something light and palatable but not necessarily nutritious. Accordingly my own contribution "The Knights of Malta" will be entertaining (I hope) rather than instructive, although it may be that also (I hope). Incidentally, this meeting is a combined meeting of the Society and the Medical History Section. As members of the Society you are eligible to become members of the Section, and you are invited so to become.

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Department of Health and Public Welfare

Comparisons Communicable Diseases

DISEASES	1942		1941		TOTALS	
	Sept. 10-October 7	August 13-September 9	Sept. 10-October 7	August 13-September 9	January 1-October 7, 1942	January 1-October 7, 1941
Anterior Poliomyelitis	8	6	88	463	44	970
Chickenpox	47	24	73	26	1578	1434
Diphtheria	30	8	14	7	172	116
Diphtheria Carriers	6	—	1	—	15	9
Dysentery — Bacillary	—	1	1	1	6	2
Erysipelas	3	8	2	3	76	55
Encephalitis	4	8	24	411	33	502
Influenza	1	1	8	15	177	222
Measles	18	26	47	12	4328	3140
Meningococcal Meningitis	—	2	3	2	20	42
Mumps	42	38	56	35	2730	903
Ophthalmia Neonatorum	—	—	—	—	1	2
Pneumonia — Lobar	2	—	3	11	83	86
Puerperal Fever	—	—	1	1	2	7
Scarlet Fever	29	21	54	13	1113	323
Smallpox	—	—	—	—	—	—
Tetanus	—	1	—	—	2	1
Trachoma	—	1	—	—	5	6
Tuberculosis	45	60	13	79	461	398
Typhoid Fever	9	8	5	2	25	21
Para - Typhoid	—	—	1	—	2	1
Undulant Fever	2	—	—	1	9	3
Whooping Cough	66	44	7	19	312	221
Septic Sore Throat	1	1	2	1	56	11
German Measles	—	—	3	1	259	1412
Gonorrhoea	117	119	80	91	927	841
Syphilis	50	79	34	37	524	348

This month we are showing our reported cases of communicable diseases in a different manner to the usual listing by municipalities. We would appreciate hearing any comment you may wish to make. This page is printed for your information and we wish it to be of real value.

The totals for the year to date are almost all increased with the exceptions of poliomyelitis, encephalitis, meningitis and puerperal fever, scarlet fever and diphtheria are two of the most noticeable. Scarlet has been widespread over the whole continent so we need not feel too badly about it. The City of Winnipeg contributed 14 of the 30 cases of diphtheria for this four-week period, St. Boniface 2, Dufferin 2 and there were 7 from unorganized territory.

TYPHOID FEVER showed a small outbreak in Portage la Prairie and North Norfolk. All these cases appear to trace to one which was ambulant for some time before going to hospital.

The other communicable diseases show general distribution throughout the province and no particular epidemics.

DEATHS FROM COMMUNICABLE DISEASES

August, 1942

URBAN—Cancer 39, Tuberculosis 6, Pneumonia Lobar 3, Pneumonia (other forms) 4, Syphilis 3, Lethargic Encephalitis 2, Diphtheria 1, Typhoid Fever 1, Whooping Cough 1, Meningococcal Meningitis 1, Hodgkins Disease 1. Other deaths under one year 17. Other deaths over one year 124. Stillbirths 19. Total 222.

RURAL—Cancer 23, Tuberculosis 7, Pneumonia Lobar 1, Pneumonia (other forms) 5, Lethargic Encephalitis 2, Septic Sore Throat 2. Other deaths under 1 year 18. Other deaths over 1 year 129. Stillbirths 11. Total 198.

INDIANS—Tuberculosis 4, Pneumonia (other forms) 2. Other deaths under one year 4. Other deaths over one year 5. Total 15.

DIPHThERIA: Thirty cases—we stick out like a sore thumb! Has every child been toxoided recently? Probably not!

TYPHOID FEVER: Not so satisfactory and our year looked fairly good until this little outburst ran the total up.

SMALLPOX: None reported, but don't neglect vaccination and re-vaccination.

Other diseases, our figures compare reasonably well. Ontario and Minnesota have some poliomyelitis but in comparison with their populations it is not high. We have been fortunate this year as regards polio and encephalitis but of the cases of encephalitis occurring, one-third have died.

DISEASE	Manitoba Sept. 10-Oct. 7	Ontario Sept. 6-Oct. 3	Saskatchewan Sept. 6-Oct. 3	Minnesota Sept. 6-Oct. 3	North Dakota Sept. 6-Oct. 3
Anterior Poliomyelitis	8	22	2	18	4
Meningococcal Meningitis	—	14	4	1	—
Chickenpox	47	209	69	39	—
Diphtheria	30	5	7	4	—
Erysipelas	3	7	2	—	—
Influenza	1	11	—	2	7
Leth. Encephalitis	4	—	2	1	3
Measles	18	51	56	21	13
German Measles	—	21	9	—	—
Mumps	42	443	68	—	4
Scarlet Fever	29	185	76	83	15
Septic Sore Throat	1	2	1	—	—
Bacillary Dysentery	—	—	1	3	—
Amoebic Dysentery	—	—	—	5	—
Trachoma	—	—	—	—	4
Tuberculosis	45	181	35	55	21
Typhoid Fever	9	6	2	1	1
Typh. Para-Typhoid	—	2	—	—	—
Undulant Fever	2	4	3	—	2
Whooping Cough	66	326	32	186	47
Tetanus	—	2	—	—	2
Diphtheria Carriers	6	—	—	—	—
Syphilis	50	475	—	—	35
Gonorrhoea	117	579	—	—	19